STATE OF NEW JERSEY DIVISION OF PENSIONS AND BENEFITS - STATE HEALTH BENEFITS PROGRAM

HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FORM FOR STATE CENTRALIZED PAYROLL EMPLOYEES

EMPLOYEE INFORMATION				
Em	inlovoo Namo:			
	ployee Name:		First	Middle Initial
Soc	cial Security Number:		Payroll Number:	Date:
PA	YROLL REQUEST			
	I authorize the State of New Jersey to deduct the Health Savings Account (HSA) contributions identified be pre-tax basis beginning no earlier than the date my HSA medical plan will become effective. The funds are be deposited into my Health Savings Account.			
	Contributions are subject to federal limits. Annual limits for 2013: \$3,250 for individuals; \$6,450 for families. Note: Employer contributions to your HSA count toward the annual limit.			
	Additional allowable contributions for individuals between the ages of 55 - 65: \$1,000 for the account holder only.			
	Please fill in the desired amount below.			
	Per Pay Period:			
	Contributions will begin after your HSA bank account has been opened with the banking institution selected by your provider.			
	Cancel deductions for the Health Savings Account from my paycheck.			
HE	ALTH PLAN			
Hig	jh Deductible Health Plan (HDHP) (Choos	e or	ne from below)	
	☐ NJ DIRECT HD4000		Aetna Value HD4000	
	☐ NJ DIRECT HD1500		Aetna Value HD1500	
Coverage Level (Choose one from below)				
	Single		Member and Spouse/Civil Union Partner	
	☐ Member and Domestic Partner		Family	
	☐ Parent and Child(ren)			
Em	ployee Signature:			Date:

Please return the completed form to:

NJ Department of the Treasury OMB — Centralized Payroll PO Box 207 33 W. State Street, 2nd Floor Trenton, NJ 08625